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Making the shift from hospital to the community: lessons from an evaluation of a pilot programme

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Aim: To analyse the experience of a pilot programme designed to shift care from hospital to the community. **Background:** The white paper, *Our Health, Our Care, Our Say*, published in England in 2006, set out a vision for the future of primary care and community services. A key component of this vision is to provide care closer to home. The NHS Institute for Innovation and Improvement established a pilot programme in five field test sites to explore the scope for bringing about shifts in care from hospital to the community. This paper reports the results of the evaluation of the programme. **Methods:** A comparative case study design was used including interviews with key stakeholders at different points during the pilot programme, participation in discussion groups, documentary analysis, and collation of activity and output statistics. By comparing evidence drawn from 14 projects in the five field test sites, the evaluation was able to identify the impact of different factors on the progress of the projects. **Findings:** All of the projects made some progress in taking forward their plans to shift care, although there were wide variations in what had been achieved at the end of the test and learn phase. Key factors influencing progress were the existence of a receptive context for change, project focus, organisational leadership, project management, stakeholder analysis, clinical engagement and leadership, overcoming barriers to change, aligned incentives, training and support, measuring and monitoring progress, and the timescale for change. A critical requirement in programmes of this kind is 'getting the basics right' through dogged attention to project and change management. Also important is ensuring that the evidence on change management and quality improvement is acted on by those leading change programmes.

Key words: change management; community care; quality improvement

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Introduction

The white paper, *Our Health, Our Care, Our Say*: a new direction for community services (Department of Health, 2006), published in January 2006, set out a vision for the future of primary care and community services in England. A key component of this vision is to provide care closer to home, shifting from a model of hospital-based services towards

more proactive community-based approaches. The proposals set out in the white paper include:

- shifting care within particular specialties into community settings,
- allocating a larger share of the available resources to preventative, primary, community, and social care services,
- developing a new generation of community hospitals,
- reviewing service configuration to accelerate the development of services closer to home,
- refining tariffs to provide stronger incentives for practices and primary care trusts (PCTs) to

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develop more primary and community services, and

- offering information to the public about specialist services available in the community.

While these proposals may be widely supported, there are challenges in making them happen on the ground.

Recognising these challenges, the NHS Institute for Innovation and Improvement (hereafter referred to as the NHS Institute) established a programme of work in five field test sites to explore the scope for bringing about shifts in care. The NHS Institute's 'Making the Shift' programme, as it was initially known, aimed to identify learning to inform national as well as local developments by examining how shifts could be accelerated and the factors that helped and hindered change.

At the outset, the NHS Institute identified a number of underpinning themes of the programme

and these are summarised in Box 1. The stated aims of the first phase were to:

- make a sustainable shift from acute settings to community settings,
- provide better outcomes for patients,
- get best value from resources,
- create system change faster and more effectively,
- build positive and productive relationships between all the players in the health and social care system, and
- design the future system (commissioning arrangements, financial flows, etc) on the basis of what works and how to go about it.

The NHS Institute commissioned support from the management consultants, AT Kearney, to work with the sites. A consultant from AT Kearney was assigned to each site and spent two to three days per week advising on the development of the projects, how progress would be reviewed, and

Box 1 Underpinning themes

(a) Integration

Creating effective, trusting relationships between the contributions to the health and social care system which result in seamless, integrated care; ensuring that choice and contestability are built on a platform of multi-disciplinary, multi-organisational working.

(b) Substitution

Providing more convenient and accessible care for patients by:

- **Location Substitution:** substituting high tech clinical environments for community-based settings.
- **Skills Substitution:** enhancing the skills of staff to undertake roles previously undertaken by those higher in the NHS skills escalator.
- **Technological Substitution:** maximising the use of new technologies in maintaining the individual's independence.
- **Clinical Substitution:** moving from a medical care model to self-care being supported by a broader range of care providers.
- **Organisational Substitution:** looking at a wider range of providers to those who have traditionally delivered NHS care.

(c) Segmentation

Grouping patients and designing services around them in ways that enable everyone to get the service they need and choose and everyone to flow through the system at the rate they need to go.

(d) Simplification

Counterbalancing the risk of creating extra structures and extra complexity between primary and secondary care; keeping the number of patient 'handoffs' to a minimum and ensuring that every step in the care process adds value for patients.

Ensuring that new structures have been put in place where old ones have been removed.

project management arrangements. One of the specific contributions of the consultants was to assess whether projects were appropriately designed and resourced, and whether stakeholders were on board. Projects were expected to meet criteria used at different stages of this process in order to proceed to the next stage as part of what was known as the 'gateway' process. The criteria included clarity of objectives, the way in which progress towards objectives was to be measured, the resources available to the projects, and whether the milestones set for each stage had been achieved. The number of stages used varied between five and eight depending on the sites and projects involved.

Selecting the sites

The NHS Institute wanted to include a range of areas in the programme, to encompass examples of organisations working across a whole health community, an approach based on health and social care integration, a practice-based commissioning initiative, and an area in which there was involvement from third sector organisations. The selection of sites took place during an 'observation phase' that ran from December 2005 to February 2006. In this phase, a scoping seminar was held, and the NHS Institute visited a number of areas that had come to its attention. There was also close liaison with policy leads in the Department of Health, especially in relation to the implications of the white paper that was published towards the end of the observation phase.

Site selection was informed by the experience gained by the NHS Institute's predecessor, the NHS Modernisation Agency, in its work on service improvement and redesign. Of particular importance was the need to work with sites likely to be receptive to change because of a history of partnership working and a focus on service improvement. The knowledge of the NHS Institute's team of the work that had been done in different areas played a part in the selection of sites, and helped in the decision to work with the following areas:

Birmingham – an example of working across a whole health community,

Derbyshire – an example of working with the third sector in an area with a track record of work on service improvement,

Manchester – an example of working between primary and secondary care with strong interest in practice-based commissioning,

Stour – an example of an innovative GP practice that was interested in making the shift, and

Torbay – an example of health and social care integration.

The NHS Institute acknowledged that the selection of sites had not been 'scientific' but in the context of the timescale of the programme it felt that an appropriate spread of areas and health care communities with a history of relevant work and experience had been identified for inclusion in the programme. In each site, three projects were chosen for inclusion in the programme (two in the case of Stour). The key characteristics of the 14 projects are described in Table 1.

Implementation of the programme started in June 2006 in the 'test and learn phase'. This was intended to run until the end of 2006 when it was expected that the projects would have started to make shifts in care in line with their objectives.

The evaluation

The University of Birmingham's Health Services Management Centre (HSMC) was chosen by the NHS Institute to evaluate the programme. The evaluation was designed to identify the factors that helped or hindered progress in making the shift, and the lessons for the NHS from the experience of the field test sites. HSMC was not asked to assess the extent to which shifts in care occurred during the programme, but rather to draw on the perceptions and experiences of staff in the five health care communities to develop greater understanding of the challenges facing the NHS in implementing the vision set out in the white paper and how these might be overcome. The main part of the evaluation commenced in June 2006 and concluded at the end of December 2006, with progress in five of the 14 projects being tracked until the end of March 2007.

Given the scope and timeframe of the Making the Shift programme, the HSMC team used a comparative case study design including interviews with key stakeholders in each health community, documentary analysis of project papers and other background materials, and compilation of outcomes in the later phases. To gather

Table 1 Projects participating in the 'Making the Shift' programme

Project	Planned outcomes
Birmingham <i>Segmentation and substitution of skills:</i> promoting heart failure self-management education for South Asians. <i>Integration, substitution of location, and simplification:</i> providing a back pain clinic run by a team including acute sector specialist in a primary care setting. <i>Integration, substitution of location and simplification:</i> raising awareness of primary care incontinence clinic for women.	Increased number of people interested in participating in courses and attending and completing a course; increased confidence and satisfaction among participants. Reduced number of visits, referrals, and inter-referrals; decreased waiting times; increased service user satisfaction; more cost-effective service. Reduced inappropriate outpatient referrals; reduced time from symptoms to diagnosis; more cost-effective service.
Derbyshire <i>Substitution of location:</i> admissions avoidance education programme for people with COPD (chronic obstructive pulmonary disease) based on home visits. <i>Substitution of skills and organisations:</i> using community paramedics on 999 calls to reduce admissions to hospital by referring to other services. <i>Substitution of location and simplification:</i> improving end-of-life care to reduce inappropriate admissions.	Increased confidence and satisfaction; increased people receiving self-management plans; reduced A&E admissions; cost effective. Reduction in A&E admissions; increased proportion of eligible people seen by community paramedic, referred to a community doctor, or using Red Cross services; more cost-effective service. Increased people identified and dying in their place of choice; description of current management; cost-effective service.
Manchester <i>Substitution of location and skills, and segmentation:</i> providing diabetes services in primary care rather than in secondary care. <i>Simplification and substitution of location and skills:</i> improving referral pathways for infertility treatment. <i>Simplification:</i> improving pathways for unscheduled care.	Reduced outpatient appointments for people with Type 2 diabetes; improved level of services offered by practices; increased service user satisfaction; more cost-effective service. Reduced waiting time; improved service user satisfaction. Reduced admissions and waiting time; improved staff perceptions.
Stour <i>Substitution and simplification:</i> self-monitoring of hypertension instead of appointments with a practice nurse. <i>Integration:</i> supporting people at 'high risk' of admission, by working across agencies to 'flag' unplanned contacts to a practice-based liaison nurse.	Proportion of eligible people participating in self-monitoring project; reduced appointment waiting times; reduced number of clinic appointments; improved satisfaction with services. Reduced unplanned admissions, analysis of costs.
Torbay <i>Substitution of location and skills:</i> initiating insulin in primary care rather than in secondary care. <i>Substitution of location:</i> developing a decision making tool about feasibility of projects to shift diagnostics. <i>Segmentation and simplification:</i> communication plan aimed at practitioners to improve care for people at the end of life with any diagnosis.	Increased % practices initiating insulin; reduced referrals to initiate insulin; reduced hours spent by specialist nurses on insulin initiation; increased satisfaction among service users; costs. Model development and implementation. Number of practices implementing gold standards framework (GSF); % dying in place of choice; proportion of unplanned admission dying within 48 h of admission; increased satisfaction with services; cost-effective service.

baseline information, the HSMC team arranged interviews and participated in discussion groups with representatives from the five health and social care communities. A key aim of the interviews and discussion groups was to understand what roles, relationships, and contextual factors might explain whether shifts in care do or do not occur. Those involved in leading the projects in the programme were interviewed at the outset and, as far as possible and appropriate, at the mid-point of the programme and again towards the end of the test and learn phase to establish the extent of progress, perceived helpful and hindering factors, and examples of good practice.

Over 60 people were interviewed as part of the evaluation, many on more than one occasion. The people who provided feedback included managers from NHS trusts (including Foundation Trusts and Care Trusts), project champions, clinical leads, project leads, project managers, front-line staff, including consultants, nurses, and GPs, SHA staff, NHS Institute staff, and other stakeholders with a special interest in the projects, including the voluntary sector. Participants provided feedback on the understanding that comments would not be attributable to individuals, but would instead be used to help understand themes within and between local health care communities. Only a small number of service user representatives were interviewed, because the focus was on system or organisational factors that may help accelerate change.

Information gathered from interviews was supplemented with documentary analysis of project papers and other background materials. Some of these papers had been prepared by the organisations involved in the programme prior to their selection as field test sites and helped in providing an understanding of the history of work on the 14 projects and the context in which work on shifting care was taking place. The extent of background documentation varied with some projects supplying detailed papers describing developments prior to the commencement of the programme and others having little or no previous paperwork on which the evaluation could draw. The evaluation also included papers and data produced by the projects during implementation.

The HSMC team reviewed data obtained from the interviews and documentary analysis at regular meetings where the experience of the five

sites and the 14 projects was compared and contrasted. The interview schedule used during the evaluation provided an organising framework for data analysis, enabling key themes to be identified as the programme was rolled out. These themes were summarised in an interim evaluation report submitted to the NHS Institute half-way through the test and learn phase in September 2006, setting out the early findings from the evaluation. Drafts of the interim report were shared with key stakeholders in the sites to check for accuracy and validity. A similar process was used in the preparation of the final report of the evaluation early in 2007 (Ham *et al.*, 2007a). Consistent with the nature of a formative study, the HSMC team was in regular contact with the NHS Institute throughout the evaluation, and drew on the knowledge of the Institute's staff in making sense of the data within the framework of the comparative case study design that was adopted.

While the main aim of this paper is to report and analyse the results of empirical research, the literature on the management of change is used to understand and explain the findings of this research. As previous reviews of this literature prepared for practitioners and researchers in the health sector have shown (Iles and Sutherland, 2001), many different disciplines have contributed to the study of change management, based on diverse methodologies and settings. Arising out of this work, several models and approaches have been proposed for analysing and informing change programmes.

In this study and in previous research (Ham *et al.*, 2003), we have drawn particularly on one of these approaches, namely the work of Pettigrew and colleagues with its emphasis on research on change being processual, comparative, pluralistic, and historical (Pettigrew *et al.*, 1992). We have also drawn on insights gained from previous studies of change programmes in health care undertaken by these authors and others (Shortell *et al.*, 1998) that have identified the factors that facilitate or inhibit change. The interview schedule used in the field work was informed by our understanding of the literature on the management of change, and focused on factors such as the history and context of work on making shifts in care, project management arrangements, clinical engagement and leadership, and the resourcing of the programme. In the process of

gathering data from the projects, other factors emerged as important in influencing the progress that was made, and these are reflected in this paper. The comparative case study approach enabled the evaluation team to illustrate how these factors played out in different projects, and the way in which their interaction over time influenced what was achieved.

In carrying out the evaluation, we have been alert to the possibility that the forces for continuity may be stronger than the forces for change (Pettigrew *et al.*, 2001), and of the many obstacles to the implementation of change programmes. These obstacles have been analysed by Kotter (1996) in a seminal and widely cited analysis that draws on the experience of failed change programmes to outline the steps that need to be taken to implement change effectively. Based on the results of the empirical work reported in the next section, in the discussion at the end of this paper we return to the literature on the management of change to review what our study adds to the stock of knowledge in this area. In so doing, we reflect on the impact of two rapid reviews of evidence from previous research and experience of attempting to shift care from hospital to the community that we were commissioned to undertake by the NHS Institute before the commencement of the test and learn phase (Parker, 2006; Singh, 2006). The aim of these reviews was to inform the field test sites of the evidence and experience relevant to the work they were about to embark on in the hope that this would support effective implementation.

Results

In the timescale covered by the main evaluation of the Making the Shift programme, all of the projects made some progress in taking forward their plans, although there were wide variations between projects in what had been achieved at the end of the test and learn phase in December 2006. These variations applied to the work done to prepare to shift care to different settings rather than to actual shifts in care as none of the projects was able to report major changes in where care was provided by the end of this phase. By comparing progress in the 14 projects, the evaluation was able to identify a number of lessons about

the processes involved in providing care closer to home.

Receptiveness to change

Field test sites were selected in part because there was a history of NHS organisations in the sites working together to bring about change. While this history meant the sites were well placed to take part in the programme, even more important was the degree to which projects within sites exhibited a receptive context for change. This was illustrated by the variable progress made in Derbyshire where the project on chronic obstructive pulmonary disease (COPD) had more advanced plans for making the shift at the end of the test and learn phase than the project on unscheduled care. One of the reasons for differential progress was that the COPD project built on previous work and relationships, whereas the unscheduled care project required different agencies to come together without the benefit of previous joint working. Receptiveness to change is therefore particularly important at the project level. This finding underlines the importance of 'microsystems' as the locus of change in health care organisations (Nelson *et al.*, 2002). It also raises the question as to how to link change in individual projects with change at the organisational and systems level, and we return to discuss this further below.

Project focus

A major priority in the projects in the initial stages was to agree the focus of their work. The short timescale of the programme and the expectation that some results would be demonstrated at the end of the test and learn phase resulted in most projects narrowing their focus around specific groups of patients, localities, or practices. This often occurred as part of the gateway process used by AT Kearney during the programme. As might be expected, projects in which there had been previous work spent less time discussing their focus and were better placed to begin the process of making shifts in care. An example was the Birmingham back pain service, which had already spent time developing and agreeing a new community service model. As part of deciding their focus, the projects also debated and agreed the measures and data sources they

would use to monitor progress towards their objectives, an issue we return to below.

Organisational leadership

The presence of chief executives who were visibly supportive of the programme helped to facilitate implementation. The best example of this was in Birmingham where the chief executive of one of the PCTs regularly reviewed and commented on progress reports, and intervened as necessary to overcome barriers to change. Her personal commitment to the programme made a tangible difference in this site and contributed to Birmingham being further ahead with its projects at the end of the test and learn phase than was the case in the other sites. In these sites, chief executives tended to lend their support and endorsement at one step removed, rather than through direct and active personal involvement.

Project management

The existence of adequate time and resource for project management had a critical bearing on progress in all sites. In many cases, there were difficulties in identifying the necessary time and resource, with the consequence that project managers were expected to take on the work involved in the programme in addition to existing responsibilities. Where this happened, progress tended to be slower than where dedicated project management capacity was allocated and maintained throughout the programme.

Projects in which there was a team comprising a small number of people with complementary roles and skills had an advantage over projects where this was not the case. An example was the end-of-life project in Derby that involved a team comprising a public health consultant, an experienced project manager, and an analyst. The intensive support provided by consultants from AT Kearney and staff of the NHS Institute went some way towards filling the gaps in project management in some sites, although this raised questions as to what would happen when this support was withdrawn at the end of the test and learn phase.

Stakeholder analysis

A specific aspect of project management was the involvement of appropriate stakeholders. In some projects, stakeholder analysis was undertaken at the outset and helped project staff to

engage key individuals and interests from the early stages. More often, this work was done once projects were underway, in some cases as a result of difficulties arising in the involvement of partners. One of the lessons that emerged from experience was the need to target key stakeholders able to make a real difference to a project and to focus effort on these stakeholders, rather than to attempt to adopt an all-embracing strategy. An example of this was the vulnerable patients' project in Stour, which made limited progress until a representative from the ambulance service with authority to initiate changes within his organisation became involved. This unblocked a number of the obstacles that had been encountered initially.

Clinical engagement and leadership

The engagement of clinicians and the identification of clinicians to support project managers in leading work on making shifts in care contributed significantly to the programme in a number of areas. The sites took different approaches to clinical engagement with some identifying clinicians to take on project leadership roles and others seeking to involve clinicians at particular stages of their work. Projects in which GPs worked with consultants, such as the diabetes project in Manchester, found this kind of joint clinical leadership to be particularly valuable. There were challenges for the clinicians concerned in balancing clinical commitments with involvement in the programme, especially for GPs. In some projects, nurses emerged as the most important clinical leaders, especially in those projects where skills substitution was involved. One of the most developed approaches to clinical engagement was in Torbay where a diabetes project focused on helping practices to initiate insulin used a range of methods to engage relevant clinicians.

Overcoming barriers to change

The projects found that cultural barriers between primary and secondary care could be an obstacle to change and could slow shifts in care. Overcoming these barriers was challenging in a number of sites, and required an investment of time in developing relationships and understanding between clinicians. A number of approaches were taken to this including joint meetings, facilitated redesign events, and encouraging clinicians to shadow one another. Shadowing roles proved particularly effective in

the Birmingham back pain project where the lead clinicians from primary and secondary care worked closely with practices in the introduction of the new service. Barriers also emerged in the ambulance service in implementing a new approach to responding to certain 999 calls in Derbyshire that involved helping people to remain at home rather than transferring them to hospital. In this case, project staff had to work with ambulance crews who were concerned at the risks they were being asked to take in using this approach.

Aligned incentives

Creating the right incentives to support change helped to facilitate progress in a number of projects. Both financial and non-financial incentives were important. An example of the use of financial incentives was found in the Manchester diabetes project where additional funds were made available through practice-based commissioning to pay for the extra workload involved in practices taking on more of the care of people with diabetes. An example of the use of non-financial incentives was the Birmingham integrated continence project, which was able to enlist the support of gynaecologists and urologists by demonstrating how extended nursing and physiotherapy practitioners could provide more care out of the hospital and thereby enable specialists to focus their expertise on women who required specialist intervention.

Training and support

All project teams were offered training and support from the NHS Institute and the consultants employed by AT Kearney. The focus of this support was project management and the skills needed to ensure that projects were supported by detailed plans, which included measurable objectives. The support provided was generally valued by the NHS staff involved in the programme, although some felt its timing could have been improved. Other forms of training and support focused on clinical staff. This included developing the skills of staff taking on extended roles and additional work in practices or community settings to enable shifts in care to occur. The nature of the training provided tended to be specific to each project, reflecting the service issues being addressed and the level of competence of the staff involved. In all cases,

projects reported that training was essential to enable new models of care to be implemented.

Measuring and monitoring progress

A major challenge was identifying how projects would know whether they had shifted care into the community. This challenge arose for various reasons, including lack of clarity at the outset on the scope and focus of the project, inexperience among project staff in measurement strategies and the use of datasets or questionnaires, and lack of knowledge and experience in data analysis. Over time, the projects found that two strategies were helpful in addressing these issues. The first, as discussed above, was to narrow the focus of the work and in so doing simplify the number of potential measures to be used in monitoring progress. The second strategy was to involve staff responsible for data collection and analysis to join meetings and add their expertise to the projects. The learning that arose in this area underlined the need for training and support for NHS staff in relation to measuring and monitoring progress.

Timescale for change

The short timescale of the programme posed a major challenge for all concerned. Having made this point, the participants in the programme recognised there was value in having a stretching deadline to work towards, and that this had provided a discipline that might otherwise have been lacking. In the case of projects where the context for change was receptive, it was possible in this timescale to introduce new services, and begin to see the effects on patients, albeit for very small numbers. For other projects, the time was used to undertake the planning needed to enable implementation to occur after the end of the test and learn phase. The time pressures on the projects were accentuated by the initiation of this phase in June. The summer holiday period that followed soon after meant that in most cases it was difficult to build momentum for change until the end of that period, with the consequence that a significant amount of the time allocated was in effect lost to the programme.

Sustainability and scaling up

As the test and learn phase came to an end, it was anticipated that attention would turn to the question of how projects would be sustained after

support from AT Kearney and the NHS Institute was withdrawn, and also how promising projects could be scaled up to serve larger groups of patients. With the partial exception of Birmingham, where the three projects were embedded within a wider change programme, this question was not addressed systematically. The main reason for this was that projects were still in the test and learn phase at the end of 2006, and it was therefore premature to consider issues of sustainability and scaling up. Not only this, but also some projects faced the challenge of building on the work they had done when project staff were facing the uncertainties associated with the ongoing reorganisation of PCTs, and the future of their own jobs.

Discussion

While almost all projects had made progress in taking forward their proposals by the end of 2006, and in the process had begun to establish more positive and productive relationships between different stakeholders, the test and learn phase became, in effect, a period of planning and preparation that laid the foundations for implementation but was unable to demonstrate tangible results in implementing the aims established for the programme at the outset of this paper (see Introduction). Differences between projects threw up important learning about the process of making change happen, and we now relate this learning to the literature on quality improvement and change management summarised earlier.

The results reported here reinforce the conclusions of previous studies of the impact of quality improvement programmes and especially the finding that bringing about change in health care organisations is inherently difficult and often takes longer than expected (McNulty and Ferlie, 2002; Ham *et al.*, 2003). They also underline the finding that it is the interaction of several factors over time that helps to explain the outcomes of quality improvement programmes (Walston and Kimberley, 1997). One of the consequences for those promoting change is the need to understand the complexity of quality improvement in health care and to avoid seeking simple or mechanical solutions.

In previous work, we have shown how a major NHS change programme went through a period

in which progress was made in implementing the programme's goals, only for this to be followed by a period in which some of the pilot sites backtracked and found it difficult to sustain the advances they had made (Ham *et al.*, 2003). This is a salutary reminder of the fragile and contingent nature of change in health care organisations, and the importance of different factors being aligned behind the change being made. Future programmes of this kind need to draw explicitly and systematically on the evidence base on service and quality improvement in health care organisations to support implementation of new models of care.

The paradox of the Making the Shift programme is that the NHS Institute did make use of the extensive experience of its staff in developing the programme, and also commissioned HSMC to undertake reviews of the evidence and of NHS experience (Parker, 2006; Singh, 2006). The results of these reviews were communicated both through reports and through presentations and discussion at meetings held at an early stage of the programme to bring together the programme sponsors from the NHS Institute, NHS staff from the field test sites, and the evaluation team. They were also referred to during planning meetings between the sites and the evaluators. Despite this, in the test and learn phase, there was limited evidence that projects were using the results of these reviews, with the consequences for implementation summarised in this paper. The paradox becomes even more puzzling in view of the fact that the gateway process used in the programme by AT Kearney was designed to assess whether the projects met the criteria for effective change before they were allowed to proceed.

Explaining the paradox and overcoming it requires a reappraisal of the links between researchers and practitioners and the way in which knowledge is translated into action. Even in a programme of this kind, in which the researchers brought extensive experience of working with practitioners and communicating the results of reviews of the evidence and of NHS experience in clear and non-technical language, the gap between knowing and doing proved difficult to bridge. This confirms the need for a deeper form of engagement between researchers and practitioners to overcome the old dichotomy between theory and practice (Pettigrew *et al.*, 2001).

As part of this engagement, there is a need to ensure greater awareness of research and the findings of research among practitioners, as well as closer involvement of researchers in the implementation of change programmes.

On reflection, the nature of the engagement between researchers and practitioners at the outset of the Making the Shift programme was too superficial to enable the evidence that was collated to be used effectively. It was also the case that, by the time the reviews of the evidence and NHS experience were completed, the selection of field test sites and projects had been agreed. The pressure under which practitioners were working to take forward their projects limited the time they had available to make use of the evidence and affected the impact of the reviews that were undertaken. Addressing these challenges is likely to require a much closer partnership between researchers and practitioners linked to a rigorous process to assess whether change projects are acting on the evidence before they take forward implementation. In the international context, the experience of organisations like the Canadian Health Services Research Foundation that have pioneered the fostering of 'linkage and exchange' between researchers and practitioners in the health sector holds pointers on how this might be done (http://www.chsrf.ca/about/history_e.php). The study reported in this paper therefore adds to the stock of knowledge on the management of change by highlighting the need for new and different relationships between researchers and practitioners to enable evidence from research to be acted on in practice.

Besides closer engagement between researchers and practitioners, a systematic investment in training and development to strengthen skills in project and change management (including skills in the use and analysis of quantitative data) would enable future improvement programmes to move further and faster in improving performance. Our evaluation shows that a key requirement in programmes of this kind is '*getting the basics right*' through dogged attention to the essentials of project and change management. One of the main obstacles to getting the basics right was a shortage of time and expertise among the NHS staff involved in the programme in project and change management. With many staff taking on responsibility for projects alongside existing roles and without always having

the training needed to lead change in complex, multi-agency environments in the face of demanding timescales, it was not surprising that progress at the end of the test and learn phase was variable and in some cases limited. Doing the project basics well by following the precepts of researchers like Kotter (1996), who have studied the ingredients of successful change management, is critical in supporting effective implementation.

Having made this point, our findings suggest that bringing about change cannot be reduced to a cookbook approach in which improvement can be assured if the evidence on change management is faithfully followed. The reality of the projects we studied was more complex and their impact depended on local circumstances (hence our emphasis on the context of change), and the interaction between the different factors discussed in this paper. As work on the quality improvement journeys undertaken by health care organisations has shown (Bate *et al.*, 2008), there is more than one way of bringing about improvement and it is the adaptation of the lessons from research into change management in different contexts that is important. This suggests that the leadership of quality improvement programmes requires a sophisticated and nuanced approach that is sensitive to the behaviours of the stakeholders involved in bringing about change. Among other things, this calls for flexible and emergent management processes that recognise the reality that in complex change initiatives it is people who deliver results (King and Peterson, 2007).

As a final comment, it is important to relate the findings reported here to the work of Ferlie and Shortell (2003) and their analysis of the issues involved in quality improvement in the UK and the US. Ferlie and Shortell argue that there are four levels of change for improving quality: the individual, the group or team, the organisation, and the larger system. These authors conclude that:

While it is possible to achieve a small, limited impact by focusing on only one of the four levels of change, we believe that the greatest and longest-lasting impact will be achieved by considering all four levels simultaneously.

(p. 288)

The Making the Shift programme concentrated on bringing about quality improvement at the level of individuals and teams, and in only one site (Birmingham) was there a systematic effort to link the programme to the organisation as a whole. The learning gained in Birmingham was incorporated into other change programmes being undertaken in that site. For the NHS as a whole, more work needs to be done to connect change and improvement in microsystems to organisations and the larger system in which they function.

High-performing organisations will only emerge when quality improvement moves beyond projects (Ham *et al.*, 2007b) to engage with change on a broader canvas. The warning from the research reported here is that if achieving change in relatively small-scale projects is as difficult as was the case in the Making the Shift programme, then there are major challenges in implementing change at the organisational and systems level. More positively, the findings of this study offer lessons on how these challenges can be addressed, and in this respect the learning thrown up by the Making the Shift programme may help to ensure that quality improvement initiatives in future are implemented more effectively and rapidly than the projects we evaluated.

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